

# NORTH TEXAS CLINICAL WEIGHT LOSS

3730 N. Josey Lane, Suite 101, Carrollton, Texas 75007 ~ 214-731-THIN (8446)

We may utilize the appetite suppressant medication, Phentermine, together with nutritional counseling and diet recommendations, as part of our medically supervised weight loss program and because of possible complications related thereto,

## **YOU CANNOT TAKE THE PHENTERMINE IF ANY OF THE FOLLOWING APPLIES:**

You currently have any of the following conditions:

- Uncontrolled high blood pressure
- Hyperthyroidism
- Heart disease (including irregular beats)
- Pregnancy (or are presently breastfeeding)
- Seizure disorder
- Glaucoma

You plan to have major surgery within the next two weeks.

You have a BMI (body mass index) of less than 27.

You are less than 16 years old. Persons between the ages of 16-18 years of age must have a BMI (body mass index) of no less than 30.

You are currently taking any of these medications:

- Nardil
- Pamate
- Marplane
- Coumadin
- Certain cardiac drugs
- MAOI's (depression medications) within the past two weeks
- Glaucoma medications (for increased pressure in your eyes)
- Adderall, Concerta, and most others for Attention Deficit Disorder (ADD/ADHD)

Or if you have any other prohibitive condition as determined by the medical provider.

**YOUR SIGNATURE BELOW ACKNOWLEDGES THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION AND YOU THAT YOU ARE NOT TAKING ANY OF THE MEDICATIONS ABOVE NOR HAVE ANY OF THE DISQUALIFYING CONDITIONS STATED ABOVE.**

Patient signature \_\_\_\_\_

Staff initials \_\_\_\_\_

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## WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE

By signing below, you acknowledge that you have received a Notice of Privacy Practice from North Texas Clinical Weight Loss Center. The notice explains manners in which North Texas Clinical Weight Loss Center may or may not use to protect your health information for treatment, payment, and health care operation purposes. "Protected Health Information" means any information, whether oral or recorded, in any medium or form by the health care provider that relates to the past, present or future mental health or physical condition of an individual.

North Texas Clinical Weight Loss Center reserves the right to have absolute authority on any modification or amendment to this Notice from time to time. Any alterations will be made clear and posted at the patient service location. In addition, a date will be made clear when upcoming changes will come into effect and an up to date copy of any current Notice will be available upon request.

### **YOUR SIGNATURE BELOW ACKNOWLEDGES THAT YOU HAVE RECEIVED NOTICE**

NAME OF PATIENT \_\_\_\_\_

INITIALS OF PARENT OR GUARDIAN, IF PATIENT IS UNDER 18 YEARS OF AGE \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

STAFF INITIAL \_\_\_\_\_

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## Patient Medical History

**Please fill this form out as accurately as possible as this information will assist us in assessing your particular problem areas and establishing your medical weight loss and management needs. Thank you for your time and patience in completing this form.**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M / F

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phones: Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: Married / Separated / Divorced / Single (never married)

Number & Ages of Children (if any): \_\_\_\_\_

### YOUR HEALTH HISTORY

To the best of your knowledge are you in good health? Yes / No

Are you under a Doctor's care at the present time? Yes / No

If yes, for what are you being treated? \_\_\_\_\_

Doctor's Name and Phone Number \_\_\_\_\_

**IF YOU DON'T HAVE A FAMILY DOCTOR, WE RECOMMEND YOU ESTABLISH A RELATIONSHIP WITH ONE.**

Previous diets you have followed? \_\_\_\_\_

Do you have any allergies to any medications? Yes / No

If Yes, to which medications? \_\_\_\_\_

Do you have any food allergies? Yes / No

If yes, to which foods? \_\_\_\_\_

Do you suffer from Frequent Headaches? Yes / No

(If you take medication for headaches, what do you take?) \_\_\_\_\_

Have you ever taken Phentermine? Yes / No If yes, when & for how long? \_\_\_\_\_

Are you taking any prescription and/or over the counter medications, at the present time? Yes / No

If yes, please specify:

Name of Medication	Taken for

## Medical History Form, cont.

Please check all that apply:

<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes (What Age? _____) <input type="checkbox"/> Cancer <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Thyroid Dysfunction <input type="checkbox"/> Heart Disease/Stroke <input type="checkbox"/> Chest Pain <input type="checkbox"/> HIV/Hepatitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Swelling of the Feet or Hands <input type="checkbox"/> Asthma <input type="checkbox"/> Migraines <input type="checkbox"/> Infertility <input type="checkbox"/> Epilepsy <input type="checkbox"/> Constipation <input type="checkbox"/> Glaucoma <input type="checkbox"/> Menopause <input type="checkbox"/> Polio <input type="checkbox"/> Jaundice <input type="checkbox"/> Lung Disease <input type="checkbox"/> Ulcers <input type="checkbox"/> Anemia	<input type="checkbox"/> Gallbladder Disorder <input type="checkbox"/> Drug abuse <input type="checkbox"/> Pneumonia <input type="checkbox"/> Cholera <input type="checkbox"/> Arthritis <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Whooping Cough <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Gout <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Malaria <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Pleurisy <input type="checkbox"/> Liver Disease <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Nervous Breakdown <input type="checkbox"/> Psychiatric Illness/Disorders <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Rheumatic Fever
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Other Serious Illness/Disease (Please explain) \_\_\_\_\_

History of Past Surgeries/Hospitalizations:

Specify: \_\_\_\_\_ Date: \_\_\_\_\_

Specify: \_\_\_\_\_ Date: \_\_\_\_\_

Specify: \_\_\_\_\_ Date: \_\_\_\_\_

### Daily Activity Level

Select one only:

\_\_\_\_\_ **INACTIVE.** No regular exercise and a sit-down job.

\_\_\_\_\_ **LIGHT TO MODERATE.** Occasionally involved in activities such as weekend golf, tennis, swimming or cycling.

\_\_\_\_\_ **HEAVY/VIGOROUS.** Participation in extensive physical exercise for at least 60 minutes.

**Rate your energy level:** \_\_\_\_\_ (1=Low, 10=High)

When you are under stress do you tend to overeat? Yes / No

Do you think you are currently undergoing a stressful situation? Yes / No

What is your "Comfort Food?" \_\_\_\_\_

Any other foods that you feel have attributed to your putting on weight? If so, what are they?  
\_\_\_\_\_  
\_\_\_\_\_

Current Weight \_\_\_\_\_(lbs.) Height \_\_\_\_\_ Desired Weight \_\_\_\_\_(lbs.)

Weight at 20 years of age \_\_\_\_\_(lbs.) Weight one year ago \_\_\_\_\_(lbs.)

What time frame would you like to be at your desired weight? \_\_\_\_\_

Do you smoke? Yes / No If yes, how many cigarettes/packs a day: \_\_\_\_\_ For how many years? \_\_\_\_\_

If you smoked previously, when did you finally quit? \_\_\_\_\_

## **FAMILY MEDICAL HISTORY**

Father: If living, current age \_\_\_\_\_ Is he in good health? Yes / No If deceased, age at death \_\_\_\_\_

Mother: If living, current age \_\_\_\_\_ Is she in good health? Yes / No If deceased, age at death \_\_\_\_\_

Has any **Blood Relative** (i.e. Father, Mother, Brother, Sister) had any of the following Diseases?

Heart Disease Who? \_\_\_\_\_

High Cholesterol Who? \_\_\_\_\_

Diabetes Who? \_\_\_\_\_

Cancer Who? \_\_\_\_\_

Obesity Who? \_\_\_\_\_

Glaucoma Who? \_\_\_\_\_

Asthma Who? \_\_\_\_\_

Epilepsy Who? \_\_\_\_\_

High Blood Pressure Who? \_\_\_\_\_

Kidney Disease Who? \_\_\_\_\_

Tuberculosis Who? \_\_\_\_\_

Psychiatric Disorder Who? \_\_\_\_\_

Heart Disease/Stroke Who? \_\_\_\_\_

HIV/Hepatitis Who? \_\_\_\_\_

**The above information is correct to the best of my knowledge.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

# **NORTH TEXAS CLINICAL WEIGHT LOSS**

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**Please list 5 SIGNIFICANT reasons you personally want to lose weight.  
(i.e. what motivated your decision to get started now)**

1. \_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_
4. \_\_\_\_\_  
\_\_\_\_\_
5. \_\_\_\_\_  
\_\_\_\_\_

**FOOD CRAVINGS: List 6 SPECIFIC things to do instead of eating when  
you get the urge to munch (i.e. hobbies, exercise, chores, etc.)  
Please list 3 activities for home & 3 activities for work.**

**Home:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Work:**

4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_